



GEORGIA MEDICAID FEE-FOR-SERVICE BENIGN PROSTATIC HYPERTROPHY (BPH) AGENTS PA SUMMARY

Preferred	Non-Preferred
Doxazosin generic Finasteride generic Tamsulosin generic Terazosin generic	Alfuzosin generic Avodart (dutasteride) Cardura XL (doxazosin extended-release) Cialis (tadalafil) Jalyn (dutasteride/tamsulosin) Rapaflo (silodosin)

LENGTH OF AUTHORIZATION: 1 Year

NOTE: Only the 2.5 mg and 5 mg strengths of Cialis are covered, but member must meet prior authorization criteria below.

PA CRITERIA:

For Alfuzosin Generic and Rapaflo

- ❖ Approvable for a diagnosis of benign prostatic hyperplasia (BPH)
- AND
- ❖ Member must have experienced ineffectiveness, allergies, contraindications, drug-to-drug interactions, or a history of intolerable side effects to at least two of the following preferred products: doxazosin, tamsulosin or terazosin.

For Avodart

- ❖ Approvable for a diagnosis of BPH
- AND
- ❖ Member must have experienced ineffectiveness, allergies, contraindications, drug-to-drug interactions, or history of intolerable side effects to the preferred product finasteride.

For Cardura XL

- ❖ Prescriber must submit a written letter of medical necessity for members with BPH stating the reason(s) the preferred products doxazosin and either tamsulosin or terazosin are not appropriate are not appropriate for the member.

For Cialis

- ❖ Approvable for the diagnosis of BPH in members without a current or past history (within past 5 years) of erectile dysfunction (ED)
- AND
- ❖ Member must have tried and failed to receive therapeutic benefit from an alpha blocker (alfuzosin, doxazosin, silodosin, tamsulosin, terazosin) given in combination with a 5-alpha reductase inhibitor (finasteride or dutasteride)
- OR



- ❖ Member must have allergies, contraindications, drug-drug interactions, or a history of intolerable side effects to all preferred alpha blockers and 5-alpha reductase inhibitors.
- ❖ Cialis is also approvable for pulmonary artery hypertension (PAH) in members younger than 18 years of age who are under the care or referral of a cardiologist or pulmonologist.

For Jalyln

- ❖ Prescribers must submit a written letter of medical necessity stating the reason(s) the two separate prescriptions, Avodart (which requires PA) and generic tamsulosin, are not appropriate for the member.

EXCEPTIONS:

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **Catamaran at 1-866-525-5827.**

PA and APPEAL PROCESS:

- ❖ For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.